Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Alan D Silberberg MD

Respondent Name
Bitco National Insurance Co

MFDR Tracking Number
M4-15-1029-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the attached claim for codes L8680 and L8680-76. I have attached all available information for these codes, including operative note and authorization documentation for these codes."

Amount in Dispute: $23,840.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2013	L8680, L8680 - 76	$23,840.00	$1,080.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 details procedures for medical documentation.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Svc lacks info needed or has billing error(s)
   - 193 – Original payment decision maintained

Issues

1. Did the carrier identify missing information need to adjudicate claim?
2. What is the rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 16 – "Svc lacks info needed or has billing error(s)." 28 Texas Administrative Code §133.210(d) states in pertinent part, "Any request by the insurance carrier for additional documentation to process a medical bill shall: (1) be in writing; (2) be specific to the bill or the bill's related episode of care; (3) describe with specificity the clinical and other information to be included in the response; (4) be relevant and necessary for the resolution of the bill; (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; (6) indicate the specific reason for which the insurance carrier is requesting the information; and (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation." Review of the submitted explanation of benefits finds no documentation to support what information was lacking to adjudicate the disputed claim lines. The response to the reconsideration request and respondent's position statement did not identify what information was missing either. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;…"

   Review of the submitted medical claim finds code L8680 – "Implantable neurostimulator electrode, each."
3. 28 Texas Administrative Code §134.203 (d) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;"… Review of Medicare Learning Matters MM8204, "April Quarterly Update for 2013 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8204.pdf," finds the allowable for the State of Texas for L8680 is $432.00. This amount multiplied by 125% (432 x 125%) = $540 x 2 = $1,080.00.
4. The total allowable for the services in dispute is $1,080.00. The carrier previously paid $0.00. Leaving a balance due to the requestor of $1,080.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $$1,080.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,080.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March 19, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.